UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

COPAXONE(glatiramer acetate**)**

Patient name:_____Medicaid or SS#_____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and opt_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

_____

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- **DOCUMENTED** diagnosis of Multiple Sclerosis

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician or pharmacy

1 year

7/7/6